WC-3 CARRIER'S C REPORT

WC-3 (Rev. 3/92)

Case No. 79900534

FOR OFFICE USE ONLY
Date Received
Mo. / Day / Yr.

Carrier Case No. 2J029128

Carrier I.D. 1110

CLAIMANT NAME AND ADDRESS

Daniel Backman
94-872 Lumiholoi St.
Waipahu, HI 96797

SOC. SEC. NO. 576-84-6611

DATE OF INJURY/ILLNESS 7/31/97

EMPLOYER First Insurance

CARRIER Continental Casualty

ADJUSTER [illegible]

ADDRESS PO Box 1320 Hon, HI 96807

INDIVIDUAL TO CONTACT J. Matson

TELEPHONE NO. 522-2291

CHECK ONE:

1. [X] DATE OF FIRST INCOME REPLACEMENT PAYMENT: 10 / 21 / 99 (MO. / DAY / YR.)
2. [ ] REOPEN CASE
3. [ ] HEARING REQUESTED
4. [ ] NO LOST TIME/MEDICAL ONLY – PAYMENT DATE (MO. / DAY / YR.)
5. [ ] FINAL PAYMENT TO PREVIOUSLY ENDED CASE FOR 19____
6. [ ] YEAR END REPORT FOR 19____
7. [ ] FINAL REPORT (COPY TO EMPLOYEE) FOR 19____

NOTE. WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE _____

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total *		$	$	$
2. Temporary Partial *		$	$	$
3. Permanent Total		$	$	$
4. Permanent Partial		$	$	$
5. Death		$	$	$
6. Disfigurement		$	$	$
7. Medical/Other Costs		$	$	$
8. Services of Attendant		$	$	$
9. Rehabilitation		$	$	$

Carrier's Comments:

Medical Deductible:

*List Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of ____/____/____ (month day year), identified as Case No. _____, the case shall be closed. This determination shall not constitute a bar to your reopen-

EXHIBIT 6

SIGNATURE James Matson

POSITION Adjuster

B 0817

10/21/99